JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

RYAN I. YAMANE
DIRECTOR
KA LUNA HO'OKELE

JOSEPH CAMPOS II
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

TRISTA SPEER
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
KA 'OIHANA MĀLAMA LAWELAWE KANAKA
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

December 3, 2024

MEMORANDUM

MEMO NO.
QI-2422
CCS-2408

TO: QUEST Integration (QI) Health Plans
Community Care Services (CCS)

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: GRIEVANCE AND APPEAL TEMPLATES

This memorandum replaces QI-2145 and CCS-2112 which was previously issued, on December 29, 2021. The following updated content will apply under the QI contract RFP-MQD-2021-008 and CCS Contract RFP-MQD-2021-010.

This memorandum details the revisions to the grievance and appeal templates, which have been updated to align with 42 CFR §438 and to streamline the text across all templates.

Please review each template carefully as there are several changes. The revisions are as follows:

Template	Revision Area
1A, 1B, 2A,2B	• Templates **1A** and **2A** have been revised and are to be used when an AOR is required. • Templates **1B** and **2B** are new and are to be used when an AOR is **not** necessary.
3	• The "Appointment of Representative" (AOR) form has been revised to

	clearly indicate that proper authorization is required for an individual to file an appeal with a health plan on behalf of the member.
4A	• The "Appointment of Representative" (AOR) section was revised.
5A and 5B	• Modified the text describing the justification of the text for the 14-day extension.
6A, 11A, 12A	• The "What If I Do Not Agree with This Decision?" section was edited. • The text regarding the continuation of services during the appeal process was added to templates **6A** and **12A** and revised in **11B.** • The "Who May File an Appeal?" section was edited. • The "Important Information About Your Appeal Rights" section was revised.
7A and 8A	• The "What If I Do Not Agree with This Decision?" section has been updated to include the HAR and CFR rules related to Authorized Representatives.
	Additional Guidance regarding Templates 7A and 8A letters: • The Resolution letter shall explicitly state the justification for the Resolution and cannot be missing or incomplete. • The Health Plan shall refrain from combining the Acknowledgement and Resolution into a single letter. The Acknowledgment and Resolution shall be communicated separately using the dedicated templates to maintain clarity and procedural transparency. • There should be a minimum of 5 days between the mailing of the Acknowledgement letter and the Resolution letter unless the case is deemed Expedited.
10A	• The "What is the Result?" section was revised. • The **"**What if I Do Not Agree with This Result?" section was revised.
	Additional Guidance regarding Template 10A Resolution of Grievance letter: • The Resolution letter shall explicitly state the justification for the Resolution and cannot be missing or incomplete. • The Health Plan shall refrain from combining the Acknowledgement and Resolution into a single letter. The Acknowledgment and Resolution shall be communicated separately using the dedicated templates to maintain clarity and procedural transparency. • There should be a minimum of 5 days between the mailing of the Acknowledgement letter and the Resolution letter unless the case is deemed Expedited.
12B	• MQD added a new template **12B,** to address situations where a member's service authorization request is partially approved/denied. In the decision section of the letter, there will be a section to insert the approved service authorizations and a section to insert the denied service authorizations.

The attached templates are to be implemented effective January 2, 2025. The templates may not be changed without MQD approval.

Health Plans shall perform a readability check at the 6.9 grade level or below on the sections of the template that Members must complete. The template text issued by MQD should not be included in the readability check.

Please contact Jon Fujii via e-mail at jfujii@dhs.hawaii.gov should you have any questions.

Attachments:	
1A	Acknowledgement of Appeal – Appointment of Representative needed– Letter (11/2024)
1B	Acknowledgement of Appeal – Appointment of Representative **NOT** needed– Letter (11/2024)
2A	Acknowledgement of Grievance – Appointment of Representative needed Letter (11/2024)
2B	Acknowledgement of Grievance – Appointment of Representative **NOT** needed Letter (11/2024)
3	Appointment of Representative – (11/2024)
4A	Denial of Fast Appeal – Letter (11/2024)
5A	Extension of Appeal Resolution – Letter (11/2024)
5B	Extension of Grievance Resolution – Letter (11/2024)
6A	Notice of Adverse Benefit Determination – Denial of Payment – Letter (11/2024)
7A	Resolution of Appeal – Letter (11/2024)
8A	Resolution of Fast Appeal – Letter 11/2024)
10A	Resolution of Grievance – Letter (11/2024)
11A	Notice of Adverse Benefit Determination – Denial of Service – Letter (11/2024)
12A	Notice of Adverse Benefit Determination – Denial of Service Authorization – Letter (11/2024)
12B	Notice of Adverse Benefit Determination – Partial Denial of Service Authorization – Letter (11/2024)

ACKNOWLEDGEMENT OF APPEAL
Appointment Of Representative Needed
[Health Plan Logo]

[Date]

[Member's Name] Member number: (Insert)
[Address of Member] Reference/Case number: (Insert)

Re: Acknowledgement of Appeal - Appointment of Representative Needed

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] received an appeal from (Insert Name) on your behalf (Insert appropriate term: letter, phone call) on (Date received) telling us they would like to file an appeal for you regarding:
<<Insert Issue(s)>>

For additional steps regarding your appeal rights please read below.

What Happens Next?

We need the attached "Appointment of Representative" form(s) to be completed so that we can notify anyone other than you of the resolution of your appeal. Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

Appointment of Representative – Your (Insert appropriate term: e.g. doctor, husband, daughter) asked to file an appeal on your behalf, and we require your signed consent to proceed with the appeal. This form allows you to designate someone to act as your representative for this appeal. We need you to fill out and sign this form to notify anyone other than you of the resolution of the appeal. Send it back to us by (Date) using the envelope we gave to you.

We will provide you with a decision within 30 calendar days of receiving your appeal request. If you do not receive a decision within that time frame or a request for an additional 14-day

extension, you can request a “State Grievance Review” with the Department of Human Services, Med-QUEST office.

You can send in any information to help you with your appeal. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:

If you need further assistance or information, contact us Monday through Friday, between 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address, this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (When applicable)

[Language Block]

ACKNOWLEDGEMENT OF APPEAL
Appointment Of Representative NOT Needed
[Health Plan Logo]

[Date]

[Member's Name] Member number: (Insert)
[Address of Member] Reference/Case number:(Insert)

Re: Acknowledgement of Appeal - Appointment of Representative **NOT** Needed

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] got your appeal (Insert appropriate term: letter, phone call) on (Date received) telling us you want to file an appeal about:
<<Insert Issue(s)>>

For additional steps regarding your appeal rights please read below.

What Happens Next?

We will provide you with a decision within 30 calendar days of receiving your appeal request. If you do not receive a decision within that time frame or a request for an additional 14-day extension, you can request a "State Grievance Review" with the Department of Human Services, Med-QUEST office.

You can send in any information to help you with your appeal. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:

If you need further assistance or information, contact us Monday through Friday, between 7:45 am and 4:30 pm Hawaii time at:

Toll-free: (Insert number)

TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address, this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (When applicable)

[Language Block]

ACKNOWLEDGEMENT OF GRIEVANCE
Appointment Of Representative Needed
[Health Plan Logo]

[Date]

[Member's Name] Member number: (Insert)
[Address of Member] Reference/Case number:(Insert)

Re: Acknowledgement of Grievance - Appointment of Representative Needed

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] received a grievance from (Insert Name) on your behalf (Insert appropriate term: letter, phone call) on (Date received) telling us they would like to file a grievance for you regarding:
<<Insert Issue(s)>>

If you do not agree with the grievance information stated above, please tell us in the space provided below. Your response is due to us within 5 business days after you receive this acknowledgement letter.

What Happens Next?

We need the attached "Appointment of Representative" form(s) to be completed so that we can notify anyone other than you of the resolution of your grievance. Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

Appointment of Representative – Your (Insert appropriate term: e.g. doctor, husband, daughter) asked to file a grievance on your behalf, and we require your signed consent to proceed with the grievance. This form allows you to designate someone to act as your representative for this

grievance. We need you to fill out and sign this form to notify anyone other than you of the resolution of the grievance. Send it back to us by (Date) using the envelope we gave to you.

We will provide you with a decision within 30 calendar days of receiving your grievance request. If you do not receive a decision within that time frame or a request for an additional 14-day extension, you can request a "State Grievance Review" with the Department of Human Services, Med-QUEST office.

You can send in any information to help you with your grievance. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:

If you need further assistance or information, contact us Monday through Friday, between 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (When applicable)

[Language Block]

ACKNOWLEDGEMENT OF GRIEVANCE
Appointment Of Representative NOT Needed
[Health Plan Logo]

[Date]

[Member's Name] Member number: (Insert)
[Address of Member] Reference/Case number:(Insert)

Re: Acknowledgement of Grievance - Appointment of Representative **NOT** Needed

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] got your grievance (Insert appropriate term: letter, phone call) on (Date received) telling us you want to file a grievance about:
<<Insert Issue(s)>>

If you do not agree with the grievance information stated above, please tell us in the space provided below. Your response is due to us within 5 business days after you receive this acknowledgement letter.

What Happens Next?

We will provide you with a decision within 30 calendar days of receiving your grievance request. If you do not receive a decision within that time frame or a request for an additional 14-day extension, you can request a "State Grievance Review" with the Department of Human Services, Med-QUEST office.

You can send in any information to help you with your grievance. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:

If you need further assistance or information, contact us Monday through Friday, between 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (When applicable)

[Language Block]

APPOINTMENT OF REPRESENTATIVE
FOR HEALTH PLAN APPEAL
[Health Plan Logo]

Date: (Insert) **Member number: (Insert)**

Member's Name: (Insert) **Reference/Case number:(Insert)**

PART 1 --- APPOINTMENT OF REPRESENTATIVE FOR HEALTH PLAN APPEAL (to be filled out by Member)

I allow _____ to act for me when filing a
(Name of person who will be Member's Representative)
grievance, claim, or appeal with my health plan.

The person I have named can act for me when giving or receiving any information about my grievance, claim, or appeal with my health plan. This includes personal medical information.

Member Name:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

For an appeal with the Department of Human Services' Administrative Appeals Office (AAO), additional forms are required. Only members or Authorized Representatives are allowed to request a hearing with AAO Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

PART 2 --- ACCEPTANCE OF APPOINTMENT (to be filled out by Member's Representative for Health Plan appeal)

| | , accept the appointment. I will

(Name of person who will be Member's Representative)

act on behalf of the member to file a grievance, claim, or appeal with the health plan.

Relationship to Member: (Must be age 18 or older)	
Representative Signature:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

This authorization is good for one year from the date you sign this form unless you tell us the following:

Date: _____/_____/_____ Or Event: _____
Month Day Year

Part 3 ---YOUR INDIVIDUAL RIGHTS (Please read):

I understand that:

- I do not have to sign this form.
- I can cancel this form by writing to [Health Plan] at the address below except for the information that was already disclosed.
- Once my protected health information is disclosed to the person or organization, I specified in **Part 1** of this form, the information in their possession may no longer be protected by privacy laws.

Member Signature: _____ Date: _____

After completing this form, please mail, fax, or deliver this form to the address below:

[Health Plan name]
[Address – Physical address or P.O. Box]
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)

[Language Block]

DENIAL OF FAST APPEAL
[Health Plan Logo]

[Date]

[Member's Name]
[Address of Member]

Member number: (Insert)
Reference/Case number: (Insert)

Re: Denial of Fast Appeal

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] got your request for a "Fast Appeal" on (Date received) about:

<<Insert Issue(s)>>

We will not do a fast review of your appeal because:

<<Insert Issue(s)>>

What Happens Next?

We will review your case as a "Standard Appeal." We will decide your appeal within 30 calendar days after we got your appeal request. We will give you a decision by (Insert date).

If you do not agree with our decision to review your case as a "Standard Appeal," you have the right to file a grievance with (Health Plan name**).** You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health Plan name]
[Address – Physical address or P.O. Box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

[If AOR is needed:]. Since your request for a "Fast Appeal" was denied, your case will be processed as a "Standard Appeal". You have the right to file a grievance review on this matter. If someone else other than you request for a grievance review regarding the "Denial of a Fast Appeal", provide the attached "Appointment of Representative" form. Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent. An Authorized Representative can be a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else you designate to act on your behalf.

Appointment of Representative (AOR) Your (Insert appropriate term: e.g. doctor, husband, daughter) asked us to review your case because your (Insert appropriate term: e.g. doctor, husband, daughter) does not agree with our decision to deny your fast appeal. We need your permission to review your case and release the information to (AOR name). Please return the form by (Date) using the enclosed envelope. We cannot review your case as requested until we receive your authorization.

You can send any information to help you with your case. You can send in this information to (Health Plan) or give us this information in person. At no cost to you, you may also ask for a copy of your file.

Contact Information:

If you need further assistance or information, or to give us more information about the "Denial of Fast Appeal", contact us Monday through Friday, between 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (When applicable)

[Language Block]

EXTENSION OF APPEAL RESOLUTION
[Health Plan Logo]

[Date]

[Member's Name] Member number: (Insert)
[Address of Member] Reference/Case number: (Insert)

Re: Extension of Appeal Resolution

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] got your appeal on (Date received) about:
<<Insert Issue(s)>>

We need more time to look at your case. We have not reached a decision at this time because (Insert reason for delay). Taking more time is in your best interest because (Insert advantage of the extension for member). We may take up to 14 more calendar days. We will give you a decision by (Insert date).

If you do not agree with the 14 calendar day extension, you have the right to file a grievance with (Health Plan name**).** You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health Plan name]
[Address – Physical address or P.O. Box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

Contact Information:

If you need further assistance or information, contact us Monday through Friday, between 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)

TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (When applicable)

[Language Block]

EXTENSION OF GRIEVANCE RESOLUTION
[Health Plan Logo]

[Date]

[Member's Name]
[Address of Member]

Member number: (Insert)
Reference/Case number: (Insert)

Re: Extension of Grievance Resolution

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] got your grievance on (Date received) about:
<<Insert Issue(s)>>

We need more time to look at your case. We have not reached a decision at this time because (Insert reason for delay). Taking more time is in your best interest because (Insert advantage of the extension for member). We may take up to 14 more calendar days. We will give you a decision by (Insert date).

If you do not agree with the 14 calendar day extension, you have the right to file a grievance with (Health Plan name**).** You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health Plan name]
[Address – Physical address or P.O. Box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

Contact Information:

If you need further assistance or information, contact us Monday through Friday, between 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)

Mail: (Insert address this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (When applicable)

[Language Block]

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF PAYMENT
[Health Plan logo]

(Notice only – This is not a bill)

[Date]

[Member's Name]
[Address of Member]

Member number: (Insert)
Reference/Case number: (Insert)

Re: Notice of Adverse Benefit Determination – Denial of Payment

Dear [Member's name]:

[Health Plan greeting approved by MQD]
[Health Plan name] is sending you this letter to tell you about our decision whether to pay for a service(s) you received.

We recently received a claim for <<Insert Service(s)>>

provided to you by <<Insert Provider Name>>
on <<Insert Date(s) of service(s)>>

We will not pay for <<Insert Service(s)>>

because [Insert appropriate reason(s): "the request did not meet the established medical necessity criteria(s) or guideline(s) at this time." "the service is not a covered service under Medicaid/The Plan." or other reason(s)]:
<<Insert Reason(s)>>

What If I Do Not Agree with This Decision?

You have the right to ask (Health Plan name**) for an appeal.** Your appeal must be filed orally or in writing within 60 calendar days after the date of this notice. If you want your service(s) to continue during the appeal, all of the following must be met:

- You must ask for service(s) to continue when you give us your appeal.

- Your appeal must be filed within 10 calendar days of this "Notice of Adverse Benefit Determination" or by the date service(s) will be changed, whichever is later.
- Your appeal must involve stopping, reducing, suspending service(s), or treatment(s) that were already approved.
- The service(s) must have been ordered by an authorized provider.
- The original approval (authorization) period has not expired.

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standard(s) on which this decision was based on, at no cost to you.

Who May File an Appeal?

A Member or an Authorized Representative can file an appeal either orally or in writing. If you would like someone to represent you, please make sure that both you and your representative sign, date, and submit a statement naming that person.

An Authorized Representative can be a family member, friend, advocate, attorney, doctor (excluding your treating physician), or anyone you designate to act on your behalf.

Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.
We have also told <<provider>> that we will not pay for (Insert appropriate term: this, these) <<service(s)>>.

Signature: (Medical Director)

c: Member (when applicable)

[Language block at end of document]

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can file:

"Standard Appeal" (decision no later than 30 calendar days) – You can ask for a "Standard Appeal". We will give you a decision no later than 30 calendar days after we get your appeal request. (An additional 14 more calendar days may be requested if we need more information or you are requesting more time. Taking more time may benefit you in our decision.)

"Fast Appeal" (decision no later than 72 hours) – You can ask for a "Fast Appeal" if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a "Fast Appeal" no later than 72 hours after we get your appeal request. (An additional 14 more calendar days may be requested if we need more information or you are requesting more time. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a "Fast Appeal" for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a "Fast Appeal."**
- If you ask for a "Fast Appeal" without information from your doctor, we will decide if your health requires a "Fast Appeal." We will notify you if we do not give you a "Fast Appeal," and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a "Fast Appeal," you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File an Appeal?

For a "Standard Appeal": We will accept appeals submitted by mail, fax, or telephone. If you wish to send an appeal by mail, you can send it to the address below:

Address: (Insert)
Fax: (Insert)
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)

For a "Fast Appeal": Contact us by telephone or
fax: (Insert)
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)
Fax: (Insert)

What Happens Next?
If you appeal, we will review our decision again. If we decide to continue your services without any changes, you will receive services right away. If we decide again that your services should be stopped, reduced, or suspended, and you still disagree with this decision, you will have the right to request a "State Administrative Hearing". You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)

RESOLUTION OF APPEAL
[Health Plan logo]

[Date]

[Member's Name]
[Address of Member]

Member number: (Insert)
Reference/Case number: (Insert)

Re: Resolution of Appeal

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] received your written appeal on (Date received) about:
<<Insert Issue(s)>>

The request has been reviewed. The review was completed by a [licensed doctor/licensed dentist/ appeals committee]. The [doctor(s)/dentist] is/are also board certified. The [doctor(s)/dentist] was not a part of the first review or the finding(s) from that review.

The Medical Director(s) involved is/are [Board Certified MD/DO with a specialty in (List Specialty and Title)].

What Is Our Decision?

(Insert decision here. Include: Date review was completed, department and/or staff involved, include title/qualifications/specialty, and any source used during the review)

Your medical records that we had available were reviewed. The first decision [First Determination] has been [upheld/overturned] based on this review. This denial was [upheld/overturned] because [List Reason(s)]. The reason(s) for denial are based on a set of standard(s)/criteria(s). This included:
[List Standard(s)/Criteria(s)]

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standard(s) on which this decision was based at no cost to you.

What If I Do Not Agree with This Decision?

You have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a "State Administrative Hearing".

Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

You may present your appeal independently or be represented by an authorized representative whom you have authorized, such as legal counsel, a relative, a friend, or another person of your choice. Also, available are interpreter services for individuals with limited English proficiency, and auxiliary aids for individuals with disabilities.

File your request for a "State Administrative Hearing" in writing within 120 calendar days of the date of this notice. Send it to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, Hawaii 96809

How Do I Request for Services to Continue during a "State Administrative Hearing"?

If the service(s) you appealed about had already been approved and the health plan decided to stop, reduce, or suspend them, you can ask that they continue during the "State Administrative Hearing" process. To do this:

- You must ask for service(s) to continue during the "State Administrative Hearing". Do this when you ask for your hearing.
- Your request for an administrative hearing must be filed within 10 calendar days from when the health plan mailed this final appeal decision, or by the date service(s) will be changed; whichever date is later.
- Your original appeal must be about service(s) or treatment(s) that was already approved that the health plan decided to stop, reduce, or suspend before it was completed.
- The service(s) must have been ordered by an authorized provider.
- The original approval (authorization) period has not expired.

If the "State Administrative Hearing" decision is the same as the appeal decision [to deny, stop, or reduce the service(s)], you may have to pay for the service(s) that you asked us to continue during the "State Administrative Hearing" process.

What Happens Next?

When the Administrative Appeals Office gets your request for a hearing, they will write to you and tell you more about the hearing process. If the decision to stop, reduce or suspend services is reversed, you will receive services right away.

Contact Information:

If you need further assistance or information, contact us Monday through Friday, between 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (when applicable)

[Language Block]

RESOLUTION OF FAST APPEAL
(Health Plan Logo)

[Date]

[Member's Name]
[Address of Member]

Member number: (Insert)
Reference/Case number: (Insert)

Re: Resolution of Fast Appeal

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] received your (Insert appropriate term: oral, written) request for a "Fast Appeal" on (Date received) about:
<<Insert Issue(s)>>

The request has been reviewed. The review was completed by a [licensed doctor/licensed dentist/ appeals committee]. The [doctor(s)/dentist] is/are also board certified. The [doctor(s)/dentist] was not a part of the first review or the findings from that review.

The Medical Director(s) involved is/are [Board Certified MD/DO with a specialty in (List Specialty and Title)].

What Is Our Decision?

[Insert decision here. Include: Date review was completed, department and/or staff involved, and any source used during the review, date verbal notification was conducted (or date message left)]

Your medical records that we had available were reviewed. The first decision [First Determination] has been [upheld/overturned] based on this review. This denial was [upheld/overturned] because [List Reason(s)]. The reason(s) for denial are based on a set of standard(s)/criteria(s). This included:
[List Standard(s)/Criteria(s)]

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standard(s) on which this decision was based at no cost to you.

What If I Do Not Agree with This Decision?

You have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a fast "State Administrative Hearing".

Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

File your request for a fast "State Administrative Hearing" in writing within 120 calendar days of the date of this notice. Send it to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, Hawaii 96809

How Do I Request for Services to Continue during a fast "State Administrative Hearing"?

If the service(s) you appealed about had already been approved and the health plan decided to stop, reduce, or suspend service(s), you can ask that they continue during the "State Administrative Hearing" process. To do this:

- You must ask for service(s) to continue during the "State Administrative Hearing". Do this when you ask for your hearing.
- Your request for an administrative hearing must be filed within 10 calendar days from when the health plan mailed this final appeal decision, or by the date service(s) will be changed; whichever date is later.
- Your original appeal must be about service(s) or treatment(s) that was already approved that the health plan decided to stop, reduce, or suspend before it was completed.
- The service(s) must have been ordered by an authorized provider.
- The original approval (authorization) period has not expired.

If the "State Administrative Hearing" decision is the same as the appeal decision [to deny, stop, or reduce the service(s)], you may have to pay for the service(s) that you asked us to continue during the "State Administrative Hearing" process.

What Happens Next?

When the Administrative Appeals Office gets your request for a hearing, they will write to you and tell you more about the hearing process. If the decision to stop, reduce or suspend service(s) is reversed, you will receive services right away.

Contact Information:

If you need further assistance or information, contact us Monday through Friday, between 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (when applicable)

[Language Block]

RESOLUTION OF GRIEVANCE
(Health Plan logo)

[Date]

[Member's Name]
[Address of Member]

Member number: (Insert)
Reference/Case number: (Insert)

Re: Resolution of Grievance

Dear (Insert Member's name):

[Health Plan greeting with MQD approval]
[Health Plan name] received your (Insert appropriate term: Written, oral) grievance on (Date received) about:
<<Insert Issue(s)>>

What is the Result?

(Insert resolution here. Include: Date review was completed, findings/resolution/ outcomes, department and/or staff involved, and any source used during the review)

You have a right to get copies of all the documents that were related to this review free of charge. You may also get a copy of the standard(s) on which this decision was based at no cost to you

What If I Do Not Agree with This Result?

You have the right to ask the Med-QUEST Division for a "State Grievance Review". File your request for a "State Grievance Review" by writing or calling them within 30 calendar days of the date of this notice. **Here is the address and phone number to use:**

Med-QUEST Division
Health Care Services Branch
P.O. Box 700190
Kapolei, HI 96709-0190
or call: (808) 692-8094

What Happens Next?

If you ask for a "State Grievance Review", the Med-QUEST Division will review your grievance and give you a decision within 90 calendar days after they get your "Grievance Review" request. The "State Grievance Review" decision made by the Med-QUEST Division will be final. You will not have any other grievance rights after that.

Contact Information:

If you need further assistance or information, contact us Monday through Friday, between 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or P.O. Box)

Signature: (Insert)

c: Member (when applicable)

[Language Block]

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF SERVICE
(Health Plan logo)

[Date]

[Member's Name] Member number: (Insert)
[Address of Member] Reference/Case number: (Insert)

Re: Notice of Adverse Benefit Determination – Denial of Service

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] is sending you this letter to tell you about a decision we made about service(s) you are receiving. We have (Insert appropriate term: stopped, reduced, suspended) coverage of the following medical service(s) or item(s) that you have been receiving:

<<Insert Issue(s)>>

We will make this change to your service(s) on (EFFECTIVE DATE OF CHANGE).

[Your transition plan to (insert appropriate term: stop, reduce, suspend) service(s) is (insert information about transition plan)]

We made the decision to (Insert appropriate term: stop, reduce, suspend) this service(s) because:

<<Insert Issue(s)>>

What If I Do Not Agree with This Decision?

You have the right to ask (Health Plan name**) for an appeal.** Your appeal must be filed orally or in writing within 60 calendar days after the date of this notice. If you want your service(s) to continue during the appeal, all of the following must be met:

- You must ask for service(s) to continue when you give us your appeal.
- Your appeal must be filed within 10 calendar days of this "Notice of Adverse Benefit Determination" or by the date service(s) will be changed, whichever is later.
- Your appeal must involve stopping, reducing, suspending service(s), or treatment(s) that were already approved.
- The service(s) must have been ordered by an authorized provider.
- The original approval (authorization) period has not expired.

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standard(s) on which this decision was based on, at no cost to you.

Who May File an Appeal?

A Member or an Authorized Representative can file an appeal either orally or in writing. If you would like someone to represent you, please make sure that both you and your representative sign, date, and submit a statement naming that person.

An Authorized Representative can be a family member, friend, advocate, attorney, doctor (excluding your treating physician), or anyone you designate to act on your behalf.

Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

Signature: (Medical Director)

c: PCP, Service Provider, and Service Coordinator (when applicable)

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IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can file:

"Standard Appeal" (decision no later than 30 calendar days) – You can ask for a "Standard Appeal". We will give you a decision no later than 30 calendar days after we get your appeal request. (An additional 14 more calendar days may be requested if we need more information or you are requesting more time. Taking more time may benefit you in our decision.)

"Fast Appeal" (decision no later than 72 hours) – You can ask for a "Fast Appeal" if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a "Fast Appeal" no later than 72 hours after we get your appeal request. (An additional 14 more calendar days may be requested if we need more information or you are requesting more time. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a "Fast Appeal" for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a "Fast Appeal."**
- If you ask for a "Fast Appeal" without information from your doctor, we will decide if your health requires a "Fast Appeal." We will notify you if we do not give you a "Fast Appeal," and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a "Fast Appeal," you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File an Appeal?

For a "Standard Appeal": We will accept appeals submitted by mail, fax, or telephone. If you wish to send an appeal by mail, you can send it to the address below:

Address: (Insert)
Fax: (Insert)
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)

For a "Fast Appeal": Contact us by telephone or
fax: (Insert)
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)
Fax: (Insert)

What Happens Next?
If you appeal, we will review our decision again. If we decide to continue your services without any changes, you will receive services right away. If we decide again that your services should be stopped, reduced, or suspended, and you still disagree with this decision, you will have the right to request a "State Administrative Hearing". You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF SERVICE AUTHORIZATION REQUEST
(Health Plan logo)

[Date]

[Member's Name] Member number: (Insert)
[Address of Member] Reference/case number: (Insert)

Re: Notice of Adverse Benefit Determination – Denial of Service Authorization Request

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] is sending you this letter to tell you about a decision we made about service(s) you or your doctor requested. We have decided to deny the request for coverage of the following medical service(s) or item(s):

<<Insert Issue(s)>>

We made the decision to deny this service(s) because:

<<Insert Issue(s)>>

What If I Do Not Agree with This Decision?

You have the right to ask (Health Plan name**) for an appeal.** Your appeal must be filled orally or in writing within 60 calendar days of the date of this notice. If you want your service(s) to continue during the appeal, all of the following must be met:

- You must ask for service(s) to continue when you give us your appeal.
- Your appeal must be filed within 10 calendar days of this "Notice of Adverse Benefit Determination" or by the date service(s) will be changed, whichever is later.
- Your appeal must involve stopping, reducing, suspending service(s), or treatment(s) that were already approved.
- The service(s) must have been ordered by an authorized provider.
- The original approval (authorization) period has not expired.

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standard(s) on which this decision was based on, at no cost to you.

Who May File an Appeal?

A Member or an Authorized Representative can file an appeal either orally or in writing. If you would like someone to represent you, please make sure that both you and your representative sign, date, and submit a statement naming that person.

An Authorized Representative can be a family member, friend, advocate, attorney, doctor (excluding your treating physician), or anyone you designate to act on your behalf.

Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

Signature: (Medical Director)

c: PCP, Service Provider, and Service Coordinator (when applicable)

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IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can file:

"Standard Appeal" (decision no later than 30 calendar days) – You can ask for a "Standard Appeal". We will give you a decision no later than 30 calendar days after we get your appeal request. (An additional 14 more calendar days may be requested if we need more information or you are requesting more time. Taking more time may benefit you in our decision.)

"Fast Appeal" (decision no later than 72 hours) – You can ask for a "Fast Appeal" if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a "Fast Appeal" no later than 72 hours after we get your appeal request. (An additional 14 more calendar days may be requested if we need more information or you are requesting more time. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a "Fast Appeal" for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a "Fast Appeal."**
- If you ask for a "Fast Appeal" without information from your doctor, we will decide if your health requires a "Fast Appeal." We will notify you if we do not give you a "Fast Appeal," and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a "Fast Appeal," you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File an Appeal?

For a "Standard Appeal": We will accept appeals submitted by mail, fax, or telephone. If you wish to send an appeal by mail, you can send it to the address below:

Address: (Insert)
Fax: (Insert)
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)

For a "Fast Appeal": Contact us by telephone or
fax: (Insert)
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)
Fax: (Insert)

What Happens Next?
If you appeal, we will review our decision again. If we decide to continue your services without any changes, you will receive services right away. If we decide again that your services should be stopped, reduced, or suspended, and you still disagree with this decision, you will have the right to request a "State Administrative Hearing". You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)

NOTICE OF ADVERSE BENEFIT DETERMINATION
PARTIAL DENIAL OF SERVICE AUTHORIZATION REQUEST
(Health Plan logo)

[Date]

[Member's Name]
[Address of Member]

Member number: (Insert)
Reference/case number: (Insert)

Re: Notice of Adverse Benefit Determination – Partial Denial of Service Authorization Request

Dear (Insert Member's name):

[Health Plan greeting approved by MQD]
[Health Plan name] is sending you this letter to tell you about a decision we made about service(s) you or your doctor requested.

We have decided to **APPROVE** the request for coverage of the following medical service(s) or item(s):

Code	Description	From Date	To Date	Authorized Units	Requested Units	Denied Units	Unit Type

We have decided to **DENY** the request for coverage of the following medical service(s) or item(s):

Code	Description	From Date	To Date	Authorized Units	Requested Units	Denied Units	Unit Type

We made the decision to deny the above service(s) because:

<<Insert Issue(s)>>

What If I Do Not Agree with This Decision?

You have the right to ask (Health Plan name**) for an appeal.** Your appeal must be filled orally or in writing within 60 calendar days of the date of this notice. If you want your service(s) to continue during the appeal, all of the following must be met:

- You must ask for service(s) to continue when you give us your appeal.
- Your appeal must be filed within 10 calendar days of this "Notice of Adverse Benefit Determination" or by the date service(s) will be changed, whichever is later.
- Your appeal must involve stopping, reducing, suspending service(s), or treatment(s) that were already approved.

- The service(s) must have been ordered by an authorized provider.
- The original approval (authorization) period has not expired.

You have a right to get copies of all the documents that were a part of this review free of charge. You may also get a copy of the standard(s) on which this decision was based on, at no cost to you.

Who May File an Appeal?

A Member or an Authorized Representative can file an appeal either orally or in writing. If you would like someone to represent you, please make sure that both you and your representative sign, date, and submit a statement naming that person.

An Authorized Representative can be a family member, friend, advocate, attorney, doctor (excluding your treating physician), or anyone you designate to act on your behalf.

Under HAR §17-1703 1-3(c) and 42 CFR §438.402(c)(1)(ii), a provider or authorized representative can file an appeal for a member if the member gives written consent.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

Signature: (Medical Director)

c: PCP, Service Provider, and Service Coordinator (when applicable)

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IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can file:

"Standard Appeal" (decision no later than 30 calendar days) – You can ask for a "Standard Appeal". We will give you a decision no later than 30 calendar days after we get your appeal request. (An additional 14 more calendar days may be requested if we need more information or you are requesting more time. Taking more time may benefit you in our decision.)

"Fast Appeal" (decision no later than 72 hours) – You can ask for a "Fast Appeal" if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a "Fast Appeal" no later than 72 hours after we get your appeal request. (An additional 14 more calendar days may be requested if we need more information or you are requesting more time. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a "Fast Appeal" for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a "Fast Appeal."**
- If you ask for a "Fast Appeal" without information from your doctor, we will decide if your health requires a "Fast Appeal." We will notify you if we do not give you a "Fast Appeal," and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a "Fast Appeal," you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File an Appeal?

For a "Standard Appeal": We will accept appeals submitted by mail, fax, or telephone. If you wish to send an appeal by mail, you can send it to the address below:

Address: (Insert)
Fax: (Insert)
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)

For a "Fast Appeal": Contact us by telephone or
fax: (Insert)
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)
Fax: (Insert)

What Happens Next?
If you appeal, we will review our decision again. If we decide to continue your services without any changes, you will receive services right away. If we decide again that your services should be stopped, reduced, or suspended, and you still disagree with this decision, you will have the right to request a "State Administrative Hearing". You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone: (Insert)
TDD/TTY: (Insert)